

The Significance of Culture and Ethnic Minority Status as Determinants of Health and Implications for Health Promotion Practice

Introduction

Over the past few decades, there has been a great level of interest in the impact of social, cultural and economic factors on the overall health and quality of life of populations all over the world (Shankar et al, 2013). According to Castañeda et al (2015), all over the world patterns of health, illness and mortality are often founded on the nature and characteristics of existing social structures, legal and economic policies and institutions. This is due to the influence that these factors have on demonstrated social, economic and political conditions within that population (Castañeda et al, 2015). One of the main patterns that are increasingly evident is the presence of differences between general populations and diverse minority groups (Williams et al, 2010; Paradies et al, 2013; Paradies et al, 2015). This essay examines the importance or relevance of culture and ethnic minority status as determinants of health. It begins with a description of the role of culture and ethnicity on health and health-related patterns of behaviour. It then continues with an assessment of the impact of ethnicity on socioeconomic status as well as the impact of ethnicity on access and utilisation of available health care services. It does this by using relevant examples to illustrate these factors. It then goes on to highlight how such information could be of benefit for health promotion professionals, teams and organisations seeking to develop tailored interventions. Finally, it concludes by highlighting the potential for health promotion and other interventions in the future.

The Role of Culture and Ethnicity as a Determinant of Health

In considering the concepts of social determinants of health, the focus has often been predominantly on factors such as socioeconomic status, level of education, standard of

living, areas and nature of residence and the means by which they exert an influence on patterns of health, health related behaviour as well as access and utilisation of available health care services (Smedley, 2012; Hansen, 2014; Marmot & Allen, 2014). However, for some clinical conditions, differences in age, gender, standard of living and socioeconomic status, patterns of health related behaviours are not always sufficient to account for differences or disparities in health occurring between different groups of individuals (Bell et al, 2010; Smedley, 2012; Hansen, 2014).

The World Health Organisation (WHO) defines social determinants of health as *'the conditions in which people are born, grow, live, work and age'* (Viner et al, 2012 p. 1641). These conditions can be influenced by the income, resources and opportunities available to populations at any single point in time (Viner et al, 2012). These in turn are a reflection of current patterns of power, public policy as well as supporting legal frameworks guiding the function of the health and social care systems (Woolf & Braveman, 2011; Marmot & Allen, 2014; Bourgois et al, 2017). While the factors listed above can have an impact on these elements of people's lives, it must also be recognised that culture and ethnicity can influence on social interactions, the personal identity and health related choices and behaviours of individuals belonging to these cultural and ethnic groups (Ford & Harawa, 2010; Martinez et al, 2015; Walker et al, 2016). This is important in an era that is characterised by patterns of global migration including from lower income, less developed to higher income, more developed countries of the world (Ingleby, 2012; Hansen, 2014). This has led to an increasing diversity in many countries where populations are made up of individuals and communities from different ethnic and cultural backgrounds (Brondolo et al, 2009; Braveman et al, 2011; Martinez et al, 2015).

In many countries including the United States, certain disease conditions (including but not limited to diabetes and hypertension) have been discovered to be more predominant among racial and ethnic minority groups than in white populations (Bell et al, 2010; Ford & Harawa, 2010; Walker et al, 2016). According to Walker et al (2016), in addition to the higher burden of diabetes in these groups, there is a relatively greater occurrence of related complications as well as lower demonstrable self-management abilities among black and ethnic minority groups. It must be considered that cultural beliefs including diet and exercise behaviours can have an impact on patterns of health related and health seeking

behaviours among ethnic groups (Abubakar et al, 2013; Walker et al, 2016). This is important for diabetes and hypertensive heart disease where diet is an important element of self-management and control (Bell et al, 2010). Furthermore, health-seeking behaviours that are demonstrated by such groups are often a reflection of their cultural norms, values and beliefs which might influence their choices at any single point in time (Ford & Harawa, 2010). This includes the time in disease course that they chose to access formal health care services (Abubakar et al, 2013).

The nature of the relationship that exists between different ethnic groups and the society in which it is located is another factor that can impact their overall health and well-being (Ford & Harawa, 2010). Long-standing patterns of societal inequalities mean that many black and ethnic minority groups are faced with inequitable access to financial, educational and social resources within the societies in which they reside (Ford & Harawa, 2010). While the impact of poor socioeconomic status (SES) cannot be ignored, it must be acknowledged that there is also the potential for ill-health to lead to a slow fall in income and therefore socioeconomic status due to the inability to work and earn a living (Braveman & Gottlieb, 2014). However, it must also be recognised that socially disadvantaged neighbourhoods or communities are often characterised by relatively poor access to good housing, poor availability of healthy food options such as fresh fruits and vegetables and fewer opportunities for healthy exercise through safe parks and recreational centres (Bourgois et al, 2017). These factors in turn influence demonstrated health related behaviours (such as diet and exercise) and therefore overall health and well-being of the affected population (Braveman et al, 2011).

It is suggested that ethnic and cultural backgrounds could possibly influence the extent to which individuals access health care services regardless of their availability (Hansen, 2014). However, quality of care received by minority patients is sometimes suggested to be lower than that received by the White counterparts even when levels of access are taken into consideration (Smedley, 2012). For example, Bourgois et al (2017) report that research has demonstrated that women and African Americans are less likely to receive treatment for acute myocardial infarction on presentation at accident and emergency departments despite symptoms pointing to this diagnosis. Such inequitable access to needed care is thought to occur due to a variety of reasons including stereotyping and relative practitioner

uncertainty about the culturally sensitive approach to health care (Smedley, 2012). Patients and providers could hold subconscious preconceptions, biases and attitudes that are often reflective of wider societal beliefs and structures of the health organisation (Williams et al, 2010; Raphael, 2011; Paradies et al, 2013; Paradies et al, 2015). Subtle markers such as accent, bearing, demographic characteristics, gender, and sexuality have been found to sometimes influence judgements in a manner that could potentially limit an individual's ability to make significant achievements and advancements in their society (Bourgois et al, 2017). This highlights the potential for patient and/or provider bias and preconceptions to influence the extent to which individuals can benefit from available health care services.

It is also recognised that there are significantly higher risks of uncontrolled hypertension in blacks with diabetes than in non-Hispanic blacks, or white populations (Walker et al, 2016). Effective management of diabetes in this racial group will therefore be facilitated by a recognition of this increased risk and the active implementation of suitable therapeutic measures to avoid this complication (Woolf & Braveman, 2011). Similarly, a lack of suitable knowledge and awareness amongst health professionals can create a barrier to successful management of these conditions and therefore to short-, medium- and long-term health and well-being in these populations. This therefore highlights the fact that there are different means by which culture and ethnicity can have an impact on the health and well-being of black and ethnic minority populations (Betancourt et al, 2003; Smedley, 2012; Hansen, 2014). Continued patterns of migration and resulting demographic changes in countries all over the world highlight the need for efforts that seek to reduce the impact of these disparities (Betancourt et al, 2003; Braveman et al, 2011; Walker et al, 2016; Bourgois et al, 2017). This in turn leads to the question of how health promotion practitioners can develop interventions that contribute towards improvements in the overall health and well-being of these targeted populations.

Health promotion practice is aimed at developing, designing and implementing programmes that provide relevant health related information while also working to develop a surrounding environment that encourages the targeted populations to adopt suitably positive health behaviours and practice (Sørensen et al, 2012). It is recognised that the concepts of culture and ethnicity and the manner in which they influence population health are complex (Bourgois et al, 2017). As a result, there is therefore unlikely to be a one-size-

fits-all solution that can be adapted as a means of improving the health and well-being of black and ethnic minority populations in any country (Van Beurden et al, 2011). One of the main factors that are of relevance is capacity building. There is also a need for improved knowledge about the influence of these determinants on health, health seeking behaviour and treatment in health care facilities. It is important to begin the development of structures, policies, guidelines, policies as well as accompanying structures that can facilitate the introduction of change in relation cultural and ethnic determinants of health in present day society (Van Beurden et al, 2011; Batras et al, 2014).

Valuable knowledge and skills for the health care workforce can be improved by the introduction of cultural sensitivity training that can increase their insights into cultural determinants of health in these populations and facilitate the consideration of these elements in the development and implementation of therapeutic measures (Williams et al, 2010; Raphael, 2011; Paradies et al, 2013; Paradies et al, 2015). This is within the context of a system where there is broad-based multi-sector action on social determinants of health by active engagement and participation of relevant stakeholders including government agencies, health and social care organisations, policy makers and agencies (Laverack & Mohammadi, 2011). This includes increasing access to education, jobs, affordable housing which are all factors that can contribute to improvements in overall population health and well-being (Thornton et al, 2016). It is anticipated that the adoption of such broad based actions will contribute to significant reduction in the negative impact of such determinants of health in these populations over the next few years.

Conclusion

Over the past few decades, recognition of the impact of a variety of contextual social and personal patient characteristics on patient health and well-being has led to a focus on socioeconomic determinations of health. However, it has also become increasingly evident that culture and ethnic minority status can also influence health and health outcomes. Culture and ethnicity have an impact on social interactions, personal identity, beliefs, values, health-related choices and behaviours. Genetic patterns also mean that certain ethnicities are at an increased risk of certain conditions and negative short-, medium- and long-term effects. Furthermore, in some societies, culture and ethnicity is a major influence

on levels of formal education; accommodation, jobs and income, all of which can influence health and well-being. Finally, inherent societal norms and perceptions creates patient and provider bias that can affect both degree of access to and levels of effectiveness of accessed health care services. It is therefore concluded that there is a role for broad, multi-sector based health promotion that functions to improve socioeconomic status of all populations while increasing cultural sensitivity and therefore reducing the opportunity for bias and prejudice that could potentially influence quality and outcomes of care in these populations. It is anticipated that when such measures are developed and implemented in a manner tailored towards the specific context in which they are to be utilised, there will be demonstrable improvements over time.

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